STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155042	A. BUILDING 00 B. WING	01/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOX RIDGE HEALTH INVESTORS LLC	3801 OLD BRUCEVILLE RD BOX 136 VINCENNES, IN 47591

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey Dates: 1/11, 1/12, 1/13, 1/17, 1/18, 1/19, 1/20, 1/23/12 Facility Number: 000016 Provider Number: 155042 AIM Number: 100291500 Survey Team: Martha Saull, RN TC Carole McDaniel, RN Terri Walters, RN Ann Marie Crays (1/12/12) Census Bed Type: SNF: 23 SNF/NF: 101 Total: 124 Census Payor Type: Medicare: 23 Medicaid: 79 Other: 22 Total: 124 Stage 2 Sample: 22 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review 1/30/12 by Suzanne Williams, RN			

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F0164 SS=D	The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. Based on observation, record review and interview, the facility failed to ensure privacy during 1 of 1 gastric tube medication administration and 2 of 2 grooming observations (resident fingernail clipping and hair care) involving 3 residents randomly observed on 2 of 4 units (CD unit and EF unit). Residents #2, #66, #97 Findings include:	F0164	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request that the plan of correction be considered our allegation of compliance effective February 22, 2012 to the annual licensure survey conducted on January 11,	02/22/2012

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	1. Resident #66's clinical record was reviewed on 1/18/12 at 11:05 A.M. Her current January 2012 physician orders included, but were not limited to: Lortab 5-500 mg - take 1 tablet per peg tube every six hours for pain. On 1/18/12 at 10:15 A.M., LPN #1 was observed administering Resident # 66's Lortab 5/500 mg per peg tube. Resident #66 was sitting up in her bed in her room. Resident #66's privacy curtain had been pulled between her and her roommate but did not block the view by the room door. Resident #66's bed was the bed by the room door. During this treatment CNA #4 entered the room twice passing ice water in this room and opening the room door and the view of the room to the hall. CNA #3 also entered to assist Resident # 66's roommate which had opened the view of Resident #66 to the hall way where staff and residents were passing by. 2. On 1/19/12 at 9:28 A.M., Resident # 97 was observed sitting in her wheelchair in the lobby area of Hall D which had the TV on for resident viewing. LPN # 2 was observed in the lobby area of hall D at his time trimming Resident #97's fingernails of both hands. This lobby area had residents and staff of Hall D passing by.		2012 through January 23, 2012. **F164 It is the practice of Willow Manor to always assure that residents receive privacy during personal care.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** Resident #2 is receiving services in a manner that enhances their privacy. Resident #66 is receiving medications in a manner that promotes privacy. Resident #97 is receiving services in a manner that enhances privacy. ***Other residents that have the potential to be affected have been identified by:*** All residents have been reviewed to assure that each resident receives services in a manner that enhances privacy. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** All nursing staff has been in-serviced related to providing privacy during any type of personal care or G-tube medication administration in accordance with facility policy. Via routine rounds and the Quality Assurance process, management staff will be observing for any issues related to provision of privacy. Any issues observed will be immediately corrected. ***The corrective action taken to monitor performance to assure compliance through quality***	

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	On 1/23/12 at 12:10 P.M., the Administrator and the Director of Nursing (DON) were made aware of the lack of privacy during peg tube treatment on 1/18/12 at 10:15 A.M., and the clipping of a residents's fingernails in the hall lobby area on 1/19/12 at 9:28 A.M. At this time the DON did not provide any information regarding privacy. 3. On 1/19/12 at 9:45 A.M., CNA #10 was observed caring for Resident #2. The resident had wet hair which the CNA was brushing and fixing. This was being done in the doorway of the room of two residents across the hall from the resident's own room. Resident #2 was a dependent resident who had been put in that location by the CNA. The two residents who lived in that room were Resident #131 and Resident # 152, and both were in the room at the time. The CNA did not knock or ask permission to enter their room as she placed Resident #2 there and began brushing and fixing the wet hair. Resident # 152 was observed to spend most of each survey day seated in her chair facing the doorway and looking out into the hall. She watched the grooming care of Resident #2 throughout		***assurance is:***A Performance Improvement Tool has been initiated that randomly reviews 5 residents related to provision of privacy during care and medication pass. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed. ***The date the systemic changes will be completed:*** February 22, 2012	

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	the process. Passersby also observed the care. They included two visitors, maintenance man #2 , a physical therapy staffer and the unit manager. Interview with CNA#10 at this time indicated she had chosen that location for grooming the resident to "move her away" from her own roommate, who wanted to sit in their doorway. 3.1-3(o)			

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F0241 SS=D	The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.			
	Based on observation, record review and interview, the facility failed to ensure a resident's dignity was maintained for 1 of 22 residents reviewed for dignity in a Stage 2 sample of 22. Resident #8 Findings include: On 1/13/12 at 1 P.M., Resident #8 was observed walking down the C unit hall. She was observed ambulating with a walker and had slipper socks on her feet. CNA (certified nursing assistant) was walking beside the resident, holding a clear bag with personal clothing items in it. A male resident was observed sitting in his wheelchair in the C unit hall. As Resident #8 and CNA #1 passed the male resident, he stated to CNA #1 "She can't go out with no shoes on." CNA #1 then said "I had to take them off cause she peed on them." During this interaction, other staff and/or individuals were observed in the hall. On 1/20/12 at 12 P.M., the clinical record of Resident #8 was reviewed. A MDS	F0241	**F241** **It is the practice of Willow Manor to always assure that residents are respected and treated in a dignified manner.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** Resident #8 receives all services in a manner that enhances dignity. ***Other residents that have the potential to be affected have been identified by:*** All residents are receiving services in a manner that enhances dignity. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** All nursing staff has been in-serviced to assure that dignity is provided to each resident during care. Via routine rounds and Quality Assurance monitoring, management will be observing for issues related to dignity. Any issues will be immediately corrected. ***The corrective action taken to***	02/22/2012

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	(minimum data set assessment) was dated 10/7/11 and indicated the resident had a total cognition score of 9, which indicated the resident was of moderately impaired cognition. The MDS also indicated the resident was currently on a toileting program and occasionally incontinent of urine. On 1/23/12 at 1 P.M., the Administrator was interviewed. She was made aware of the above interaction. The Administrator indicated CNA #1 should not have verbally responded to the male resident as she did about Resident #8. 3.1-3(t)		***monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly reviews 5 residents related to dignity. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed. ***The date the systemic changes will be completed:*** February 22, 2012	

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F0254 SS=C	The facility must provide clean bed and bath linens that are in good condition. Based on observation and interview, the facility did not provide adequate numbers of wash cloths and towels for resident care on 4 of 4 units. This had the potential to impact all 124 residents. Findings include: On 1/12/12 at 10:15 A.M. anonymous CNA#25 indicated the 2 closets on (C D) wing had no wash cloths or towels. The CNA indicated staff run out of towels and wash cloths and have to go to another unit or laundry to get them. On 1/12/12 at 10:20 A.M., anonymous CNA #26 on the Alzheimer's unit (A B) indicated there were no towels or wash cloths on that unit. The CNA indicated they run out of towels and wash cloths in early morning just when they are needed and have to borrow them from other units if they are there to borrow "but the truth is we do whatever we have to, to get by. I have cleaned up BM with pillow cases." On 1/12/12 at 10:30 A.M. on the E and F unit there were 4 towels and 2 wash cloths in the closets. CNA # 27 and #28 confidentially indicated there were frequent morning shortages and most of the linen was in the condition observed.	F0254	**F254** **It is the practice of this facility to assure that there is clean bed and bath linens available that are in good condition.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** No specific residents were identified. New towels and wash clothes were purchased by the facility ***Other residents that have the potential to be affected have been identified by:*** All residents have the potential to be affected. Please see system changes below for means to prevent reoccurrence. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The facility has purchased new towels and wash clothes. There will be a minimum of 3 Par available in the facility at all times. The Housekeeping/Laundry Supervisor is responsible for assuring that linen par is adequate and that all linens are in good condition. The Laundry Department and Nursing Department has been in-serviced	02/22/2012

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	Towels and washcloths available at that time were exceedingly rough and abrasive/ exfoliating to the touch. On the AB unit, 1/12 at 11:15 A.M., CNA # 29 and #30 indicated they ran out of towels and wash cloths in the early morning "Just when showers are going on" and "If we have them there are never enough." "We can get them later in the day from the laundry but we are out when we need them." On the skilled unit (G H I), on 1/12/12 at 11:20 A.M., CNA # 31 indicated running out early in her shift and going to the laundry to get washcloths. The CNA indicated there was one wash cloth left of what had been able to get from the laundry. The CNA stated "It pays to start looking as soon as you come to work, sometimes you can use a corner of a big towel." On 1/12/12 at 11:30 A.M. two laundry staff indicated they did their best to keep the supply going to the units but the linen was used as fast as they could supply it, noting sometimes staff were waiting at the door to get washcloths and towels. On 1/12/12 at 11:45 AM the Administrator was informed of the shortages and provided samples of the		related to assuring that any concerns related to linen availability are brought to the attention of their respective supervisors so that they can be dealt with appropriately. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly reviews linen availability and condition. The tool specifically looks for linen availability and quality. The Administrator, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed. ***The date the systemic changes will be completed:*** February 22, 2012	

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	washcloths and hand towels which were available. She indicated she did not know what kind of fabric softener was in use and she would secure additional supplies of those linens. 3.1-19(g)(4)			

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F0315 SS=D	Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, interview and record review, the facility failed to provide supportive continence services and incontinence care for 1 of 2 residents reviewed for urinary incontinence of 6 who met the criteria for urinary incontinence. Resident #131 Findings include: The clinical record of Resident #131 was reviewed on 1/23/12 at 1:10 P.M. The 8/18/11 admission Minimum Data Set Assessment (MDS) of Resident #131 indicated diagnoses of Alzheimer's, anxiety, depression, diabetes mellitus and gastroesophageal reflux disease. The urinary continence status portion of the MDS indicated the resident had 7 or more episodes of urinary incontinence but at least one episode of continent voiding. It indicated there had been no trial toileting program, scheduled toileting, prompted voiding or bladder training.	F0315	**F315** **It is the practice of Willow Manor to assure that our residents receive appropriate services and treatments to prevent urinary tract infections and restore as much normal bladder function as possible.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** Resident #131 has had a tracking completed related to incontinence and receives services in a manner that promotes as much normal bladder function as possible based on the assessment. ***Other residents that have the potential to be affected have been identified by:*** All residents that are identified as having any incontinent episodes have been reviewed and are receiving services in a manner that promotes as much bladder function as possible.	02/22/2012

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	On 8/11/11 there had been an Admission Nursing Assessment and data collection tool completed prior to the above MDS. The urinary incontinence portion indicated the resident was "incontinent at times." The category of Risk Factors was left blank. That assessment had direction printed in bold type "IF INCONTINENT, COMPLETE A 3 DAY BLADDER TRACKING." Documentation was lacking of any tracking for actual assessment of pattern or frequency for determination of resident's ability to be continent with supportive service. The Care Plan that was formulated on 8/19/11 stated a goal of "Resident will be checked and changed every 2 hours to maintain dignity daily through next review" and directed "Provide Peri care after each episode of incontinence." The next review (Quarterly Nursing Assessment) was completed on 11/18/11. It indicated the resident was incontinent of urine. Documentation was lacking to indicate the bolded direction for 3 day bladder tracking was then performed. On 11/18/11 the Quarterly MDS indicated the resident was always incontinent with no episodes of continent voiding.		***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** At the time of admission/readmission, each resident will have an incontinence assessment completed. Based on the assessment, if the resident has any incontinence, a 3 day bladder tracking will be implemented. Based on the bladder tracking, an individualized program will be established if possible based on the resident's ability to train. Each assessment will be updated and reviewed quarterly in correlation with the MDS assessment period. The nursing staff has been in-serviced related to incontinence tracking, toileting, and incontinence care. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that will be utilized to observe for the provision of incontinence care. The tool will review proper assessment with correlating interventions and proper incontinence care. The tool will randomly review 5 residents to assure that proper interventions	

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	Documentation was lacking of care and service provision to attempt urinary continence support since admission. The plan of care remained unchanged. On 1/18/12 at 7:00 A.M. documentation on the drug administration record indicated the resident had received the diuretic Lasix 20 mg by mouth. On 1/18/12 from 9:00 A.M. to 1:45 P.M. the dependent resident was observed to sit in her wheel chair without check or change or position change. At 1:45 P.M., CNAs # 11 and #12 pivot transferred the resident to bed while a student nurse aide observed. The resident's sweat pants and incontinent brief were saturated with urine and the wheel chair seat had pooled urine under the waffle cushion. Upon removal of soiled garments the resident was noted to have deep indentations on the backs of thighs, in gluteal folds and on lower buttocks. There was a strong ammonia character to the urine odor. CNA # 11 referred to the indentations saying, " those are from her chair actually she looks pretty good compared to how she gets sometimes. We can put cream on for that." CNA #12 got a tube of EPC (Extra Protective Cream) and applied a thick coating over the surface of the urine damp buttocks without any skin cleansing. The EPC tube directions were		are in place related to the promoting as much bladder function as possible. The Director of Nursing, or designee, will complete this audit weekly x3, monthly x3, then quarterly x3. Any issue identified will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed. ***The date the systemic changes will be completed:*** February 22, 2012	

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	to cleanse skin, let it dry and then apply cream to the cleansed skin. The medical record review indicated a history of urinary tract infection, last treated with Cipro antibiotic series 7/1-7/6/11. The MDS Coordinator was interviewed on 1/20/12 at 9:15 A.M. She indicated the facility did not actually do bladder tracking for assessment. She indicated she had been aware there was insufficient data to assess a pattern of incontinence/ continence in the facility data collection system. She indicated she had been thinking the facility needed to collect a 3 day detailed tracking in order to assess actually what the resident needed in terms of a program. The undated Policy and Procedure for Assessing Bowel and Bladder Habits included the following: "Upon completion of 5 day Bowel and Bladder monitoring record, an evaluation/ summary should be done on each resident. Each resident will be monitored for 5 days upon admission and quarterly thereafter unless a significant change has occurred. The resident may benefit from either Formal bladder retraining program or scheduled toileting or Formal Bowel			

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	155042	A. BUILDING 00 B. WING	01/23/2012

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	Program. 1. 5 day monitoring record will be placed in C.N.A. flow records. 2. C.N.A. should check resident every hour, toilet etc. as usual 5 day period. 3. A checkmark shall be placed in the box every hour followed by the signature of the C.N.A. completing the task. 4. If the resident should have none of the appropriate boxes then N/A or dry next to the signature." 3.1-41(a)(1) 3.1-41(a)(2)			

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F0322 SS=D	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. Based on observation, interview and record review, the facility failed to ensure medication administration per gastric tube (peg/enteral tube) followed facility policy for 1 of 1 gastric medication administration randomly observed. Resident #66 Findings include: 1. Resident #66's clinical record was reviewed on 1/18/12 at 11:05 A.M. Her current January 2012 physician orders included but were not limited to: Lortab 5-500 mg - take 1 tablet per peg tube every six hours for pain. Another order (initiation date 9/29/09) indicated to check placement and residual prior to each feeding if residual > 60 ml; hold & notify physician. On 1/18/12 at 10:00 A.M., LPN #1 crushed Lortab 5-500 mg in 30 cc of water to administer per gastric tube. LPN #1 indicated he would proceed to administer the medication by checking for residual feeding. LPN #1 indicated he did	F0322	**F322** **It is the practice of this facility to assure that residents who receive medications per G-tube receive them in accordance with the facility policy.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** Resident #66 receives medications via G-tube in accordance with the facility policy. ***Other residents that have the potential to be affected have been identified by:*** All residents are receiving their medications in accordance with the facility policy related to checking of placement with G-tubes. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** All nurses have been in-serviced related to checking of G-tubes placement prior to medication administration in accordance with	02/22/2012

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	not usually check for placement of the tube per auscultation per stethoscope. At this time, the Director of Nursing (DON) was made aware of LPN #1 not proceeding to check for placement of the gastric tube before medication administration. The DON indicated she wasn't sure of facility policy but would check. On 1/18/12 at 10:15 A.M., LPN #1 indicated the DON had indicated to use a stethoscope to check placement before medication administration. At that time LPN#1 got a stethoscope and checked placement before the Lortab was administered. On 1/18/12 at 10:18 A.M., a facility policy entitled "Enteral Tube Medication Administration" (no date) was received from the DON. The policy indicated, "Purpose: to safely and accurately administer oral medications through an enteral tube." "... Procedure 1. Pull privacy curtain. Glove hands. 2. If resident is bed, elevate head of bed to 45-degree angle. 3. Verify tube placement. a. Unclamp tube and use the following procedures: b. Insert a small amount of air into the tube with the syringe and listen to stomach with stethoscope for gurgling sounds..."		the facility policy. The policy for Enteral Tube Medication Administration has been placed in each MAR for quick access if needed by the nurses. Random reviews will occur as part of the QA process identified below. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly reviews 5 residents (if applicable) for proper medication administration when G-tube is the prescribed route of intake. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed. ***The date the systemic changes will be completed:*** February 22, 2012	

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	On 1/20/12 at 12:55 P.M., during interview with the DON, she indicated nurses were to auscultate using stethoscope to check placement of gastric tube before administration of medications. She indicated she had laminated instructions (facility policy) for all residents with gastric tubes so nurses on all units had these instructions to refer to when administering medications per gastric tubes. 3.1-44(a)(2)			

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F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.			
	Based on interview and record review, the facility failed to ensure the resident was provided adequate supervision to prevent falls for 1 of 4 residents reviewed for falls of 6 who met the criteria for falls/accidents. Resident #105 Findings include: The clinical record of Resident #105 was reviewed on 1/22/12 at 10 a.m. Diagnoses included, but were not limited to, the following: macular degeneration, high risk for falls, vascular dementia with behaviors, history stroke. The resident was admitted to the facility on 11/18/11. The MDS (minimum data set assessment) dated 11/25/11 indicated the following for the resident: Total summary score for cognition was 7, which indicated severe cognitive impairment; walking in room and corridor required extensive assistance; transfer and bed mobility required limited assistance; balance during transfers and walking is not steady, only able to stabilize with human assistance; normally used a walker frequently incontinent; history of falls. A RAP (resident assessment protocol) dated	F0323	**F323** **It is the practice of Willow to assure that residents receive adequate supervision to assist with the prevention of falls.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** Resident #105 has been reviewed and has all appropriate fall prevention interventions are in place in accordance with the plan of care. ***Other residents that have the potential to be affected have been identified by:*** All residents have been reviewed to assure that they are receiving services in accordance with the plan of care and assessed safety devices. The CNA assignment sheets appropriately address residents needs based on the assessment and a monitoring system has been implemented to assure that interventions are appropriately in place. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not***	02/22/2012

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	12/17/11 indicated the resident takes Meclizine (oral medication) to help with dizziness; uses walker and assist of 1 - 2 for transfers and walking; uses antianxiety and hypnotic medication. A Fall Risk care plan, dated 11/26/11, included, but was not limited to, the following interventions: 12/14/11 bed pressure pad alarm, ppa (personal protective alarm) in wheelchair; 12/24/11 inservice staff on alarms and not leaving resident unattended. An IDT (interdisciplinary team) progress note was dated 12/26/11 and indicated the following: "CNA (certified nursing assistant) was getting res (resident) ready for bed on 12/24/11...CNA unhooked res. PPA due to res has high risk for falls. CNA left res and retrieved a gown. At which time res slid from w/c (wheelchair) hitting head on closet door. L (left) side head received hematoma..." On 1/19/12 at 12:05 p.m., Unit Manager (UM) #1 was interviewed. UM #1 manages the locked Alzheimers Unit. She indicated the resident fell on 12/14/11 and 12/24/11. She indicated the resident had fallen on another unit in the facility on 12/14/11 and was found on the bathroom floor. UM #1 stated the resident began to decline and was moved		***recur include:*** The interdisciplinary team will be reviewing every fall to assure that appropriate interventions are in place based on the possible cause of the fall. The plan of care and the CNA assignment sheets will be updated as needed. The nursing staff has been in-serviced related to providing services to our residents in correlation with the written plan of care. The in-service also includes that residents that utilize alarms as a safety device are not to be left unattended during care. There will be routine monitoring via rounds by nurses and nursing administration to assure that safety devices are in place and functional in accordance with the residents' plan of care. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that will be utilized to randomly review 5 residents related to falls to assure that all interventions were appropriately in place and that new interventions were implemented as needed. Safety device placement and function will be specifically identified on the monitoring form. The Director of Nursing, or designee, will complete this tool weekly x3,	

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	over to the locked Alzheimers unit on 12/21/11. UM#1 indicated when the resident was on the locked Alzheimers unit, Resident #105 had a PPA (personal protective alarm) in wheelchair /recliner and a pressure pad alarm in bed. UM #1 indicated on 12/24/11, CNA (certified nursing assistant) #2 had the resident in the bathroom, unhooked the safety alarm and moved out of reach of Resident #105, and she fell out of the chair which resulted in a hematoma on the side of her head. UM #1 stated she talked to CNA #2, and he stated "I knew better." UM #1 indicated she thinks the CNA walked across the room away from the resident. UM #1 indicated CNA #2 should not have left Resident #105 unattended, resulting in a fall. UM #1 indicated on admission, 11/18/11, the resident's fall risk score was a 15, indicating a high fall risk. On 1/19/12 at 12 P.M. a current copy of the facility policy and procedure for "Incident and Accident/Fall Policy" was received from the Administrator. This policy was dated 4/2011. This policy included, but were not limited to, the following: "...residents that have a (sic) incident after admission will have interventions placed to prevent further occurrences...nurse must put appropriate interventions in place to prevent further		monthly x3, then quarterly x3. Any areas identified via the audit will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed. ***The date the systemic changes will be completed:*** February 22, 2012	

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	occurrence, nurse will update staff as to new interventions, care plans..." 3.1-45(a)(2)			

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F0329 SS=D	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on interview and record review, the facility failed to ensure the resident had adequate justification for use of hypnotics for 1 of 3 residents reviewed with hypnotics of 10 residents reviewed for medications. Resident #105 Findings include: Resident #105's clinical record was reviewed on 1/19/12 at 10 A.M. Diagnoses included, but were not limited to, the following: UTI (urinary tract infection) , macular degeneration, high	F0329	**F329** **It is the practice of Willow Manor to assure that medications are only administered when necessary with proper supportive documentation.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** Resident #105 no longer has orders for a hypnotic medication. ***Other residents that have the***	02/22/2012

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	risk for falls, vascular dementia. An MDS (minimum data set assessment) dated 11/25/11, indicated the resident uses antianxiety medication. A RAP (resident assessment protocol) for psych meds indicated: Currently receiving Ativan and Dalmane as ordered. Nurses notes, dated 11/18/11 at 6 P.M., indicated the following: "...admitted to facility...c (with) diagnosis of UTI...unable to meet adl (activities of daily living)...." Nurse notes, dated 11/19/11 at 2 A.M., indicated the following: "Resident has been on call light many times this night for A (assistance) to bathroom. Assist resident every time et (and) urinated small amounts. Says she can't sleep et wants to sit up et complained of low back and bladder pain...." Nurses notes dated 11/20/11 at 3 A.M., indicated the following: "Resident has been up to bedside commode several times...Resident has urinated several times on the floor...." Nurses notes dated 11/21/11 at 3 A.M., indicated the following: "Resident has been up to bedside commode several times this shift. Resident only urinated a scant amount of urine...."		***potential to be affected have been identified by:*** All residents that take hypnotic medications have been reviewed to assure that they are appropriate and only administered if necessary. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The nurses have been in-serviced related to the use of hypnotic medications. Hypnotic medications will not be utilized unless alternative interventions have been attempted and failed as indicated by the documentation. In addition, the interdisciplinary team will be reviewing physician orders each business morning to assure that no new orders for hypnotic medication had been received inappropriately. Nursing Management has also established a binder that tracks hypnotics for ongoing review for reduction and elimination. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly reviews 5 residents related to hypnotic drug administration. The Director of Nursing, or designee, will	

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	Nurses notes, dated 11/21/11 at 2 P.M., indicated the following: "New order for...Dalmane ...every night d/t (due to) insomnia...." A physician order, dated 11/21/11, indicated the following: "Dalmane 15mg...q (every) noc (night) d/t (due to) insomnia." A Pharmacy consult dated 12/29/11 indicated the following: "Dalmane?" No additional documentation was observed on the pharmacy consultation form. On 1/19/12 at 12:15 P.M., UM (unit manager) #1 was interviewed. She reviewed the resident's clinical record and indicated Resident #105 was on Dalmane due to insomnia but indicated documentation was lacking as to a diagnosis of such. UM #1 indicated the resident's clinical record did not include a care plan addressing insomnia. A physician order, dated 1/19/12 indicated the following: "D/C (discontinue) Dalmane 15 mg q hs (bedtime)..." Documentation was lacking in the clinical record of an assessment of the resident's insomnia and/or justification of the		complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed. ***The date the systemic changes will be completed:*** February 22, 2012	

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	initiation of the sleep medication Dalmane. 3.1-48(b)(2)			

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F0356 SS=C	The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.			
	Based on observation and interview, the facility failed to post nursing staffing information, including facility name and resident census, prominently with access to residents and visitors. This had the potential to affect all residents and visitors to the facility.	F0356	**F356** **It is the practice of Willow Manor to post nursing staffing information in accordance with the regulatory requirements.** ***The correction action taken for those residents found to be affected by the deficient practice include:***	02/22/2012

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	Findings include: On 1/11, 12, 13, 17, 18, 19, and 23/12 the facility staffing was observed between 9:30 A.M. and 10:00 A.M., to be posted on the skilled unit, near the entry door. Each posting lacked the name of the facility and the resident census. The skilled unit was located at the furthest distance to the left from the main entrance which was located in the building center with wings on each side. The building census was between 120 and 125 on those days and the building capacity was 175. The building had 4 units, each with separate entrances. The posting was not accessible to 3 units. On 11/23/12 at 10:58 A.M., Employee Schedule Specialist #1 (responsible to post the information) was interviewed. She indicated she posted the information daily at the one location and did not realize the facility name and census were lacking. She recalled at one time before the facility remodeling and merger of residents from two distinct physical structures, the posting had been included on all units. 3.1-13(a)		No specific residents were identified. The facility format for posting has been changed and now reflects all regulatory requirements and is posted on each unit. ***Other residents that have the potential to be affected have been identified by:*** All residents could potentially be affected. Please see systematic changes below to prevent reoccurrence ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The facility format for nursing staff posting has been altered to reflect the facility name and the census in accordance with the regulation. The Staffing Coordinator is responsible for posting the staffing and has received in-servicing related to the required information as well as posting at each nurses' station. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly reviews for proper posting of nurse staffing in accordance with the regulation. The Director of Nursing, or	

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			designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed. ***The date the systemic changes will be completed:*** February 22, 2012	

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F0363 SS=B	Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.			
	Based on observation, record review and interview, the facility failed to prepare meals according to menu and recipe during 2 of 2 meal preparation observations involving 2 cooks in 2 separate kitchens, which had the potential to affect 117 residents who received food from the two kitchens of 124 residents in the facility. Findings include: On 1/11/12 at 10:29 A.M., Cook #1 was observed preparing the noon meal for 74 residents residing in the upper area of the facility. She cooked country fried steak rather than country fried chicken as menued. She indicated she had read the menu incorrectly when informed and then prepared the chicken instead, per menu. The menu posted for resident anticipation was for country fried chicken. The menu called for Harvard beets, which she prepared from a recipe in the facility recipe book. The beet recipe ingredients included: canned sliced medium beets including liquids, ground cloves, sugar, cornstarch, margarine, and distilled	F0363	**F363** **It is the practice of Willow Manor to prepare meals in accordance with the menus and the recipes.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** No specific residents were identified. The menus and recipes are currently being followed in accordance with the regulation. ***Other residents that have the potential to be affected have been identified by:*** Potentially all residents could be affected. Please see systematic changes below to prevent reoccurrence. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** All dietary staff has been in-serviced related to following of the menus and recipes. The	02/22/2012

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	vinegar. The cook used pickled beets for the recipe and then included the mixture of seasonings intended for plain beets. On 1/11/12 at 10:50 A.M., Cook # 2 was observed preparing the noon meal for 48 residents residing in the lower facility. She also prepared Harvard beets. She did not use the facility recipe as above. She used the appropriate amount of beets. She did not use plain beets as intended in the recipe but pickled beets. She thickened the liquids from the beets with an unmeasured amount of cornstarch and water mixture approximately 2 cups water and 1/2 cup corn starch. The recipe called for measured portions of beets, cloves, sugar, cornstarch, margarine and vinegar based on number of servings. The cook used "about 2 1/2 ten pound cans" of beets. She indicated she chose that amount because "That's what I always use and it comes out about right." On 1/20/12 at 12:50 P.M., the Food Service Manager was interviewed and indicated she did not buy plain beets since she thought the pickled beets tasted better with the seasonings for the plain beets. She indicated she had not discussed the recipe change for relative nutritional impact with the consultant dietician. 3.1-20(i)(4)		menus are established with correlating recipes as approved by the Registered Dietician. The Dietary Manager will be responsible for assuring that the appropriate products are in place to assure that the recipes can be followed. See below for monitoring to assure recipes are being followed. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly reviews 5 meals to verify the menus and recipes were followed. The Dietary Manager, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed. ***The date the systemic changes will be completed:*** February 22, 2012	

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F0371 SS=F	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions			
	Based on observation and interview, the facility failed to provide sanitary practices in meal preparation and food storage and the areas of kitchen food processing and service, during 2 of 2 kitchen tours, with the potential to affect 117 residents who received food from the facility kitchens of the 124 residents residing in the facility. Findings include: 1. On 1/11/12 at 10:29 A.M., the tour of the upper kitchen during food preparation was observed. The hand washing sink had accumulated brown stain and residue which could be scraped off with a fingernail. The caulk at the back of the sink was jagged and had accumulated brown and dark gray matter in crevices. There were 2 skillets stored for use. Cook # 1 indicated the larger of the 2 was the only one of that size available for use. Both skillets had flaking nonstick interior surfaces and dried food matter. Cook #1 was observed during food prep	F0371	**F371** **It is the practice of Willow Manor to assure that sanitary practices are in place related to food storage and preparation.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** No specific residents were identified. The areas identified in the 2567 have been corrected as follows: The hand washing sink has been cleaned and re-caulked. The 2 skillets have been cleaned. The food prep surfaces are now being sanitized. The beverage/dairy refrigerator that has had a broken thermometer now has 2 thermometers on the inside. The iron skillet and small aluminum skillet have been replaced. The binder for recording food temperatures has been replaced. The white wall under the soap dispenser has been cleaned. The red bucket by the hand washing sink has been cleaned. The microwave has been cleaned ***Other residents that have the potential to be affected have***	02/22/2012

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	to drop a thermometer on the floor and return it to the cleaned food contact surface. She later wiped the thermometer with an alcohol pad but did not sanitize the food prep surface. The beverage/dairy refrigerator had a broken digital thermometer on the outside door. Inside there was one dial thermometer which read 44 degrees at 11:30 A.M. Dietary staff #1 indicated she took and recorded the refrigerator temperature. She was unable to read the thermometer stating she had trouble seeing it and was unsure how many points to count between black lines. She provided the clipboard on which she had recorded a temperature of 38 degrees before breakfast. Later in the day for follow up, at 12:50 P.M. and 1:20 P.M. when the refrigerator was unopened, the thermometer inside continued to read 44 degrees. 2. In the lower kitchen during food preparation at 11:45 A.M., the following was observed: There was an iron skillet stored as clean which had pitted interior surfaces and rust accumulated in the pitting. There was a small aluminum skillet stores for use. It had a nonstick inside surface which was pitted and flaking off.		***been identified by:*** All residents could potentially be affected. Please refer below to systematic changes to prevent reoccurrence ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** All dietary staff has been in-serviced related to following the cleaning schedule which includes the areas mentioned in the 2567 as well as assuring that cookware is without pitting or rusting. Maintenance will be reviewing food preparation for areas that may need re-caulking as part of preventive maintenance. The Dietary Manager is responsible for assuring that the cleaning schedule is followed, the cookware remains appropriate, and that the food preparation area is maintained in a sanitary condition. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly reviews storage and preparation of food to assure that sanitation practices are in place. The Dietary Manager, or designee, will complete this tool weekly x3, monthly x3, and then	

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	The food temperature recording book was heavily soiled with dried food matter and tacky oily outside surfaces. It was laying on a clean food prep surface. There was dry dark brown matter on the white wall under the soap dispenser by the sink which had been smeared there. The red trash bucket by the hand washing sink had accumulated food matter on the inside of the lid which had black growth of matter on its surface and a mildew odor. The microwave door was tacky with accumulated oily matter hand soil. On 1/20/12 at 12:50 P.M., the Food Service Manager was interviewed. She indicated the areas which needed cleaning and sanitizing had been on routine cleaning rotation and would be re-cleaned and staff had been reinserviced on reading thermometers. She indicated the refrigerator with the broken digital thermometer had 2 interior dial thermometers inside. 3.1-21(i)(3)		quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed. ***The date the systemic changes will be completed:*** February 22, 2012	

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F0518 SS=F	The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures.			
	Based on observation, interview and record review, the facility failed to ensure 4 of 4 laundry staff were prepared to perform fire emergency procedures in the laundry. This had the potential to impact all residents residing in the facility. Findings include: On 1/23/12 at 11:25 A.M., Laundry Staffers #1 and #2 were at work folding clothes during the dryer cycle of processing. Neither was able to say what they would do in case of a dryer fire. Staff #1 indicated she would have to ask someone what to do. Staff #2 indicated she didn't know. The Laundry Supervisor indicated the dryers were gas dryers. The three employees were not familiar with any procedure to shut off gas supply in the event of a fire. Staff #1 said she would call maintenance to do that. Maintenance Staff (MS) #2 was interviewed directly thereafter. He indicated the gas should be shut and he would come from wherever he was on the property and shut the gas off at the main	F0518	**F518** **It is the practice of Willow Manor to assure all staff is educated related to emergency procedures.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** No specific residents were identified. The staff identified has been in-serviced related to emergency procedures. ***Other residents that have the potential to be affected have been identified by:*** Potentially all residents could be affected. Please see below for systematic changes to prevent reoccurrence. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** All staff has been in-serviced related to information on emergency procedures including gas shut off. Random interviews with staff will occur to assure their knowledge of emergency procedures as part of the QA process.	02/22/2012

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	outside control. Upon observation of the control, it was in the back of the facility, outdoors. It was coated with paint and did not appear ever to have been moved. He indicated it would require a special wrench which he would have to get from the maintenance department. He indicated it would require quite a lot of strength which most women could not provide. The MS located a gas valve for each dryer in the service room behind the wall on which the dryers were installed. The valves were obscured by heavy layers of dust and inaccessible except by ladder or step stool which were not provided. He indicated there was not an actual plan for gas flow interruption during a fire from the dryers. Documentation of inservicing of all 4 personnel was available, however the inservice and drills were not specific to the laundry area. During interview with the Administrator on 1/23/12 at 1:10 P.M. she indicated there was not a Policy or Procedure for fire in the laundry but the facility was immediately developing one. 3.1-51(b)		***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly interviews 5 staff members related to knowledge of emergency procedures. The Administrator, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed. ***The date the systemic changes will be completed:*** February 22, 2012	

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